citybenefits newdirections

Retiree Benefits Summary 2005

To City of Long Beach Retirees

Welcome to Open Enrollment 2005. The City is once again pleased to offer you a variety of quality health care plans to meet your needs. This year, we are introducing **New Directions** for your City benefits. Due to continuing double-digit increases in the cost of our plans, **New Directions** brings significant plan changes. Depending on the plan you choose, you may be paying more for coverage than what you paid in the past. Yet even with this change, the City's retiree health plan benefits remain extremely competitive when compared with those offered by similar employers.

The bottom line is that health care costs continue to rise at alarming rates. Our overall costs for health benefits, driven by hospital (inpatient and outpatient) and pharmacy charges, continue to increase dramatically. Our plan design changes are one way to help mitigate these rising costs without reducing the quality and value of the plans you have come to count on as City retirees. (Please keep in mind that changes to the City's plans do not affect Medicare changes in any way.)

It is critical this year for you to review your printed materials before making decisions about your benefits. An overview of the plan changes is listed below, but this overview does not include all of the important details, such as new deductible and copayment amounts. Refer to the charts that follow for additional information.

For Retirees Under Age 65—Not Eligible for Medicare

- The Long Beach Choice POS / Great-West POS Plans are being replaced by the revised POS 100 Plan, or POS 90 Plan, depending on the plan you choose. Both new plans are the same except for the percentages paid. The POS 100 Plan pays 100% of covered in-network expenses after deductible, while the POS 90 Plan pays 90% of covered in-network expenses after deductible. Covered out-of-network expenses for both plans are paid at 50% after deductible. Refer to the benefits comparison grid for more information.
- The High, Value and Low PPO Plans are being replaced by a single PPO Plan that pays 80% of most in-network services after the deductible, and 60% of most out-of-network services after the deductible.
- A High Deductible PPO Plan is being added for those who are willing to pay higher deductibles ($1,000 per person / $2,000 per family) before receiving plan benefits. This plan pays 90% of most in-network services up to specified limits (after deductible), and 60% of most out-of-network services up to specified limits (after deductible).
- A three-tier prescription drug plan with formulary, administered by EXPRESS SCRIPTS, will replace the existing prescription drug program for the POS 100 Plan, POS 90 Plan, and PPO Plan. The copays will be $10 for Generic drugs; $25 for Brand Preferred; and the higher of $40 or 30% for Brand Non-Preferred. Mail Order services are available at two times the applicable copay for a 90-day supply.

Please note that the formulary for the new prescription drug program administered by EXPRESS SCRIPTS includes the top 25 prescription drugs most commonly used by City employees and retirees, based on our utilization reports. This new plan continues to offer the convenience and cost effectiveness of mail order services (two-times the copayment for a 90-day supply). If you take maintenance medications and are not using mail order services, you are missing an opportunity to save money.

For Retirees Age 65 and Over — Eligible for Medicare

- A three-tier prescription drug plan with formulary, administered by EXPRESS SCRIPTS, will replace the existing prescription drug program for the City's Medicare Supplement Plan administered by Great-West. The copays will be $10 for Generic drugs; $25 for Brand Preferred; and the higher of $40 or 30% for Brand Non-Preferred. The $2,000 annual maximum still applies. Mail Order services are available at two times the applicable copay for a 90-day supply.
- PacifiCare's Medicare Coordination of Benefit Plans (High and Low Options) will no longer be available.
- PacifiCare's Secure Horizons plan is still available and there are no benefit changes to this plan.

It's Your Turn to Enroll

The choices you make during this Open Enrollment will be effective from February 1, 2005 through January 31, 2006. Please review your options and make your selections carefully. If you or your spouse will turn 65 at any time during the coming plan year, be sure to factor this into your decisions for 2005.

If you have access to a computer, you may want to visit your plan's website for up-to-date provider information, wellness tips and helpful advice on how to make the most of your coverage, or to review and print a copy of the plan's drug formulary. For Great West Healthcare members, the website address is **www.mygreatwest.com**. PacifiCare members should log on to **www.pacificare.com**.

You are also encouraged to attend the Question and Answer presentation by insurance company representatives to be held at the Main Library, Lower Level, from 10:00 a.m. to 12:00 p.m. on Friday, October 8. If you have questions or need more information, please contact Human Resources at (562) 570-6302.

Have a safe and healthy year.

Sincerely,

Deborah R Mills

DEBORAH R. MILLS
Employee Benefits & Services Officer

Comparison of Medical Plan Benefits For Retirees Under Age 65 and Not Eligible for Medicare

This table summarizes benefits for each of the City's medical plans. Your cost for coverage depends on the plan you choose. Plan year deductibles are the amounts you pay each year (where applicable) before your plan begins paying benefits.

	POS 100 Plan	POS 90 Plan	PPO Plan	High Deductible PPO Plan	PacifiCare of California High Plan *PCP/PMG Approved Care Only* **	PacifiCare of California Low Plan *PCP/PMG Approved Care Only* **
Plan Year Deductible	***In-Network:*** $100 individual $200 family ***Out-of-Network:*** $300 individual $600 family	***In-Network:*** $100 individual $200 family ***Out-of-Network:*** $300 individual $600 family	***In-Network:*** $300 individual $600 family ***Out-of-Network:*** $500 individual $1,000 family	***In-Network:*** $1,000 individual $2,000 family ***Out-of-Network:*** $1,000 individual $2,000 family	$0	$0
Annual Maximum	***In-Network:*** Unlimited ***Out-of-Network:*** $500,000	***In-Network:*** Unlimited ***Out-of-Network:*** $500,000	***In-Network:*** Unlimited ***Out-of-Network:*** $500,000	***In-Network:*** Unlimited ***Out-of-Network:*** $500,000	Unlimited	Unlimited
Covered Expense/Out-of-Pocket Limit	***In-Network:*** Not applicable ***Out-of-Network:*** No limit	***In-Network:*** Plan pays 100% after you reach $25,000 (i.e. $2,500 of out-of-pocket expenses excluding deductibles & copayments) for each covered person ***Out-of-Network:*** No limit	***In-Network:*** Plan pays 100% after you reach $30,000 (i.e. $6,000 of out-of-pocket expenses excluding deductibles and copayments) for each covered person ***Out-of-Network:*** No limit	***In-Network:*** Plan pays 100% after you reach $25,000 (i.e. $2,500 of out-of-pocket expenses excluding deductibles & copayments) for each covered person ***Out-of-Network:*** No limit	$1,000 annual copay maximum per individual (limit of three per family)	$1,500 annual copay maximum per individual (limit of three per family)
Hospitalization	***In-Network:*** 100%* ***Out-of-Network:*** 50%* up to covered daily maximum of $300 ($150 a day paid maximum)	***In-Network:*** 90%* ***Out-of-Network:*** 50%* up to covered daily maximum of $300 ($150 a day paid maximum)	***In-Network:*** You pay $200 per confinement, then covered at 80%* ***Out-of-Network:*** You pay $500 per confinement, then covered at 60%* up to covered daily maximum of $300 ($180 a day paid maximum)	***In-Network:*** 90%* ***Out-of-Network:*** 60%* up to covered daily maximum of $300 ($180 a day paid maximum)	Semi-private room or ICU with ancillary services covered in full for unlimited days (include SMI benefits mandated by AB88)	Semi-private room or ICU with ancillary services covered after $250 copay per admission plus 20% copayment for unlimited days (include SMI benefits mandated by AB88)
Hospital Preadmission Tests	***In-Network:*** 100%* ***Out-of-Network:*** 50%*	***In-Network:*** 90%* ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 60%*	100%**	100%**
Inpatient & Outpatient Surgery	***In-Network:*** 100%* ***Out-of-Network:*** 50%*	***In-Network:*** 90%* ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 60%*	100%**	100%**
Physician Charges for Hospital Care & Surgery	***In-Network:*** 100%* ***Out-of-Network:*** 50%*	***In-Network:*** 90%* ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 60%*	100%**	100%**

* Paid after the deductible **Non-approved care is not covered. Care must be approved by PCP or PMG (Participating Medical Group). ***PCP is your Primary Care Physician

Comparison of Medical Plan Benefits For Retirees Under Age 65 and Not Eligible for Medicare (cont.)

	POS 100 Plan	POS 90 Plan	PPO Plan	High Deductible PPO Plan	PacifiCare of California High Plan *PCP/PMG Approved Care Only* **	PacifiCare of California Low Plan *PCP/PMG Approved Care Only* **
Emergency Room	***In-Network:*** 100% after you pay $75. Payment waived if hospitalization follows. If possible, contact your PCP for instructions. Otherwise, seek treatment at the nearest facility, then contact your PCP within 48 hours to receive highest plan benefits. ***Out-of-Network:*** 50%*	***In-Network:*** 100% after you pay $75. Payment waived if hospitalization follows. If possible, contact your PCP for instructions. Otherwise, seek treatment at the nearest facility, then contact your PCP within 48 hours to receive highest plan benefits. ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 60%*	$50 copayment per visit. Waived if admitted to the hospital.	$50 copayment per visit. Waived if admitted to the hospital.
Physician Office Visits	***In-Network:*** You pay $20 at the time of visit, then covered at 100% ***Out-of-Network:*** 50%*	***In-Network:*** You pay $20 at the time of visit, then covered at 100% ***Out-of-Network:*** 50%*	***In-Network:*** You pay $25 at the time of visit, then covered at 100% ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 60%*	$10 copay per visit	$20 copay per visit
Outpatient X-ray & Laboratory	***In-Network:*** 100%* ***Out-of-Network:*** 50%*	***In-Network:*** 90%* ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 60%*	Covered in full	Covered in full
Maternity Care	***In-Network:*** 100%* ***Out-of-Network:*** 50%*	***In-Network:*** 90%* ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 60%*	Covered in full except for certain elective procedures, which are subject to copays.	Covered in full for outpatient visits; covered at 80% after $250 copay per admission for hospitalization. Certain elective procedures subject to various copays.
Birthing Centers	***In-Network:*** 100% (24-hour stay starting at child's birth) ***Out-of-Network:*** Same as In-Network	***In-Network:*** 100% (24-hour stay starting at child's birth) ***Out-of-Network:*** Same as In-Network	***In-Network:*** 100% (24-hour stay starting at child's birth) ***Out-of-Network:*** Same as In-Network	***In-Network:*** 100% (24-hour stay starting at child's birth) ***Out-of-Network:*** Same as In-Network	100%**	100%**
Adult Physical & Routine Well-Baby Care	***In-Network:*** You pay $20 at the time of visit, then covered at 100%. Women can self refer for one annual OB/GYN visit within their doctor's managed physician group. ***Out-of-Network:*** 50%* up to $250 per year	***In-Network:*** You pay $20 at the time of visit, then covered at 100%. Women can self refer for one annual OB/GYN visit within their doctor's managed physician group. ***Out-of-Network:*** 50%* up to $250 per year	***In-Network:*** You pay $25 at the time of visit, then covered at 100% ***Out-of-Network:*** 60%* up to $250 per year	***In-Network:*** Some services covered at 100% with no deductible up to $200 per year ***Out-of-Network:*** 60%* up to $200 per year	Covered in full after $10 copayment. (Waived for Well-Baby Care for children under 2) Limited to one exam each calendar year	Covered in full after $20 copayment. (Waived for Well-Baby Care for children under 2) Limited to one exam each calendar year

* Paid after the deductible **Non-approved care is not covered. Care must be approved by PCP or PMG (Participating Medical Group). ***PCP is your Primary Care Physician

Comparison of Medical Plan Benefits For Retirees Under Age 65 and Not Eligible for Medicare (cont.)

	POS 100 Plan	POS 90 Plan	PPO Plan	High Deductible PPO Plan	PacifiCare of California High Plan *PCP/PMG Approved Care Only ** *	PacifiCare of California Low Plan *PCP/PMG Approved Care Only ** *
Prescription Drugs	***In-Network:*** When you use an Express Scripts pharmacy: $10 generic; $25 brand preferred; $40 or 30% for brand non-preferred. Mail Order available at 2 times applicable copay for 90-day supply ***Out-of-Network:*** When you use non-Express Scripts pharmacy, you must file a claim form with Express Scripts; the benefit amount paid will be reduced	***In-Network:*** When you use an Express Scripts pharmacy: $10 generic; $25 brand preferred; $40 or 30% for brand non-preferred. Mail Order available at 2 times applicable copay for 90-day supply ***Out-of-Network:*** When you use non-Express Scripts pharmacy, you must file a claim form with Express Scripts; the benefit amount paid will be reduced	***In-Network:*** When you use an Express Scripts pharmacy: $10 generic; $25 brand preferred; $40 or 30% for brand non-preferred. Mail Order available at 2 times applicable copay for 90-day supply ***Out-of-Network:*** When you use non-Express Scripts pharmacy, you must file a claim form with Express Scripts; the benefit amount paid will be reduced	Covered under medical plan; subject to deductible & coinsurance ***In-Network:*** Plan pays 90%* ***Out-of-Network:*** Plan pays 60%*	You pay $5 per generic, $15 per brand; $25 per non-formulary Mail order services available at 2 times the regular copay for 90-day supply	You pay $5 per generic, $15 per brand; $25 per non-formulary Mail order services available at 2 times the regular copay for 90-day supply
Chiropractic Care	***In-Network:*** Self-referral benefit, no PCP approval required. If you use ASHP network chiropractors, plan pays 100%* of contracted charges (up to $30 paid per visit) up to $1,000 a year. ***Out-of-Network:*** Self-referral benefit, no PCP approval required. If you use non-network chiropractor, plan pays 50%* of covered charges up to a $60 per visit maximum ($30 paid per visit) up to $1,000 a year	***In-Network:*** Self-referral benefit, no PCP approval required. If you use ASHP network chiropractors, plan pays 90%* of contracted charges (up to $30 paid per visit) up to $1,000 a year. ***Out-of-Network:*** Self-referral benefit, no PCP approval required. If you use non-network chiropractor, plan pays 50%* of covered charges up to a $60 per visit maximum ($30 paid per visit) up to $1,000 a year	***In-Network:*** When you use the ASHP chiropractic network, plan pays 80%* of network contracted charges (up to $30 paid per visit) up to $1,000 a year. ***Out-of-Network:*** Plan pays 50%* of covered charges up to a $60 per visit maximum ($30 paid per visit) up to $1,000 a year.	***In-Network:*** When you use the ASHP chiropractic network, plan pays 90%* of network contracted charges (up to $30 paid per visit) up to $1,000 a year. ***Out-of-Network:*** Plan pays 50%* of covered charges up to a $60 per visit maximum ($30 paid per visit) up to $1,000 a year.	$10 copayment; 40 visits (combined with acupuncture) per year through ASHP provider	$15 copayment; 20 visits per year through ASHP provider
Acupuncture	***In-Network:*** 50%* of covered charges up to $60 per visit ($30 paid per visit) up to a $1,000 plan year maximum ***Out-of-Network:*** Same as In-Network	***In-Network:*** 50%* of covered charges up to $60 per visit ($30 paid per visit) up to a $1,000 plan year maximum ***Out-of-Network:*** Same as In-Network	***In-Network:*** 50%* of covered charges up to $60 per visit ($30 paid per visit) up to a $1,000 plan year maximum ***Out-of-Network:*** Same as In-Network	***In-Network:*** 50%* of covered charges up to $60 per visit ($30 paid per visit) up to a $1,000 plan year maximum ***Out-of-Network:*** Same as In-Network	$10 copayment; 40 visits (combined with chiropractic) per year through ASHP provider	Not covered
Durable Medical Equipment (DME)	***In-Network:*** With approval from your PCP, the plan pays 100%* when you rent or purchase DME from a contracted facility ***Out-of-Network:*** 50%*	***In-Network:*** 90%* ***Out-of-Network:*** 50%*	***In-Network:*** 80%* ***Out-of-Network:*** 60%*	***In-Network:*** 90%* ***Out-of-Network:*** 60%*	100%**	100%**

* Paid after the deductible **Non-approved care is not covered. Care must be approved by PCP or PMG (Participating Medical Group). ***PCP is your Primary Care Physician

Comparison of Medical Plan Benefits For Retirees Under Age 65 and Not Eligible for Medicare (cont.)

	POS 100 Plan	POS 90 Plan	PPO Plan	High Deductible PPO Plan	PacifiCare of California High Plan *PCP/PMG Approved Care Only ** *	PacifiCare of California Low Plan *PCP/PMG Approved Care Only ** *
Hearing Aids	***In-Network:*** 100%* up to $1,000 every 3 years ***Out-of-Network:*** 50%* up to $1,000 every 3 years	***In-Network:*** 90%* up to $1,000 every 3 years ***Out-of-Network:*** 50%* up to $1,000 every 3 years	***In-Network:*** 80%* up to $1,000 every 3 years ***Out-of-Network:*** 60%* up to $1,000 every 3 years	***In-Network:*** 90%* up to $1,000 every 3 years ***Out-of-Network:*** 60%* up to $1,000 every 3 years	100%; limit of one for each ear in a 3-year period** (hearing exam covered in full after $10 copay)	Not covered. (hearing exam covered after a $20 copayment)
Orthotics	***In-Network:*** 100%* up to $75 every 3 years ***Out-of-Network:*** 50%* up to $75 every 3 years	***In-Network:*** 90%* up to $75 every 3 years ***Out-of-Network:*** 50%* up to $75 every 3 years	***In-Network:*** 80%* up to $75 every 3 years ***Out-of-Network:*** 60%* up to $75 every 3 years	***In-Network:*** 90%* up to $75 every 3 years ***Out-of-Network:*** 60%* up to $75 every 3 years	Not covered	Not covered
Vision Benefits	***In-Network:*** Examinations covered at 100% if MES network used. Standard frames and lenses covered in full every 24 months if MES network provider used. ***Out-of-Network:*** If non-network provider used, benefits paid according to maximum allowable expense schedule: Ophthalmologic exam–$67.50; optometric exam–$57.50; Frames–$40; Lenses: $45 (single vision), $63 (bifocal), $80 (trifocal) ; Contact lenses–$100 ($250 if required due to special conditions). See plan booklet for complete schedule.	***In-Network:*** Examinations covered at 100% if MES network used. Standard frames and lenses covered in full every 24 months if MES network provider used. ***Out-of-Network:*** If non-network provider used, benefits paid according to maximum allowable expense schedule: Ophthalmologic exam–$67.50; optometric exam–$57.50; Frames–$40; Lenses: $45 (single vision), $63 (bifocal), $80 (trifocal) ; Contact lenses–$100 ($250 if required due to special conditions). See plan booklet for complete schedule.	***In-Network:*** Examinations covered at 100% if MES network used. Standard frames and lenses covered in full every 24 months if MES network provider used. ***Out-of-Network:*** If non-network provider used, benefits paid according to maximum allowable expense schedule: Ophthalmologic exam–$67.50; optometric exam–$57.50; Frames–$40; Lenses: $45 (single vision), $63 (bifocal), $80 (trifocal) ; Contact lenses–$100 ($250 if required due to special conditions). See plan booklet for complete schedule.	***In-Network:*** Examinations covered at 100% if MES network used. Standard frames and lenses covered in full every 24 months if MES network provider used. ***Out-of-Network:*** If non-network provider used, benefits paid according to maximum allowable expense schedule: Ophthalmologic exam–$67.50; optometric exam–$57.50; Frames–$40; Lenses: $45 (single vision), $63 (bifocal), $80 (trifocal) ; Contact lenses–$100 ($250 if required due to special conditions). See plan booklet for complete schedule.	Eye exam covered in full once every 12 months at MES facility. Lenses covered in full if network provider used; $60 frame allowance every 12 months; Covered through Medical Eye Services (MES)	Eye exam covered in full once every 12 months at MES facility. Lenses covered in full if network provider used; $60 frame allowance every 12 months; Covered through Medical Eye Services (MES)
Inpatient Mental Health & Substance Abuse Treatment	***In-Network:*** 100%*; 30-day plan year benefit; 60 days lifetime ***Out-of-Network:*** 50%* covered up to a $300 per day maximum ($150 per day paid benefit); 30-day plan year benefit; 60 days lifetime	***In-Network:*** 90%*; 30-day plan year benefit; 60 days lifetime ***Out-of-Network:*** 50%* covered up to a $300 per day maximum ($150 per day paid benefit); 30-day plan year benefit; 60 days lifetime	***In-Network:*** You pay $200 per confinement. Then covered at 80%* up to $15,000 per plan year for all inpatient care ***Out-of-Network:*** You pay $500 per confinement. Then covered at 60%* up to $300 per day ($180 paid maximum per day) $15,000 per plan year maximum for all inpatient care	***In-Network:*** 90%* up to $15,000 per plan year for all inpatient care ***Out-of-Network:*** 60%* up to $300 per day ($180 paid maximum per day) $15,000 per plan year maximum for all inpatient care	Covered in full for unlimited days; members must access PacifiCare Behavioral Health Network. (Substance abuse subject to $25,000 annual and $35,000 lifetime maximum for inpatient & outpatient care combined)	Covered at 80% after $250 copay per admission for mental health. Substance abuse covered at 100% subject to $25,000 annual and $35,000 lifetime maximum for inpatient & outpatient care combined. Members must access PacifiCare Behavioral Health Network

* Paid after the deductible **Non-approved care is not covered. Care must be approved by PCP or PMG (Participating Medical Group). ***PCP is your Primary Care Physician

Comparison of Medical Plan Benefits For Retirees Under Age 65 and Not Eligible for Medicare (cont.)

	POS 100 Plan	POS 90 Plan	PPO Plan	High Deductible PPO Plan	PacifiCare of California High Plan *PCP/PMG Approved Care Only* **	PacifiCare of California Low Plan *PCP/PMG Approved Care Only* **
Outpatient Mental Health & Substance Abuse Benefits	***In-Network:*** You pay $20 per visit, then covered at 100%, 20 visits per plan year maximum benefit for all outpatient care **Self-Referral Restriction:** You can only self refer to an Associated Therapists provider to receive in-network benefits. See your handbook for details. ***Out-of-Network:*** 50%* of up to $75 of covered charges per visit; 20 visits per plan year maximum benefit for all outpatient care	***In-Network:*** You pay $20 per visit, then covered at 100%, 20 visits per plan year maximum benefit for all outpatient care **Self-Referral Restriction:** You can only self refer to an Associated Therapists provider to receive in-network benefits. See your handbook for details. ***Out-of-Network:*** 50%* of up to $75 of covered charges per visit; 20 visits per plan year maximum benefit for all outpatient care	***In-Network:*** You pay $25 per visit. Then psychologists are covered at 100%; psychiatrists are covered up to $75 per visit. $1,500 plan year maximum for all outpatient care. ***Out-of-Network:*** 60%* covered up to $75 per visit. $1,500 plan year maximum or all outpatient care.	***In-Network:*** Psychologists are covered at 90%*; psychiatrists are covered at 90%* up to $75 per visit. $1,500 plan year maximum for all outpatient care. ***Out-of-Network:*** 60%* covered up to $75 per visit $1,500 plan year maximum or all outpatient care.	Covered in full after $10 copayment per visit for mental health; unlimited visits. Covered at 100% for substance abuse; subject to $25,000 annual and $35,000 lifetime maximum for inpatient & outpatient care combined. Members must access PacifiCare Behavioral Health Network	Covered in full after $20 copayment per visit for mental health; unlimited visits for SMI; limited to 30 visits per year for all other outpatient mental health benefits. Covered at 100% for substance abuse; subject to $25,000 annual and $35,000 lifetime maximum for inpatient & outpatient care combined. Members must access PacifiCare Behavioral Health Network
Lifetime Maximum Benefit for Mental Health Treatment	***In-Network:*** 60-day maximum for all inpatient care ***Out-of-Network:*** Same as In-Network	***In-Network:*** 60-day maximum for all inpatient care ***Out-of-Network:*** Same as In-Network	***In-Network:*** $50,000 for all inpatient & outpatient care ***Out-of-Network:*** Same as In-Network	***In-Network:*** $50,000 for all inpatient & outpatient care ***Out-of-Network:*** Same as In-Network	Unlimited, except as noted above for substance abuse	Unlimited, except as noted above for substance abuse
Skilled Nursing Facilities (SNF)	***In-Network:*** 100%* Limited to 90 days per plan year ***Out-of-Network:*** 50%* Limited to 90 days per plan year	***In-Network:*** 90%* Limited to 90 days per plan year ***Out-of-Network:*** 50%* Limited to 90 days per plan year	***In-Network:*** 80%* Limited to 90 days per plan year ***Out-of-Network:*** 60%* up to $90 per day Limited to 90 days per plan year	***In-Network:*** 90%* Limited to 90 days per plan year ***Out-of-Network:*** 60%* up to $90 per day Limited to 90 days per plan year	Covered in full up to 100 consecutive days from first treatment per disability	Covered at 80% up to 100 consecutive days from first treatment per disability
Home Health	***In-Network:*** Plan pays 100% of reasonable & customary charges for visits to home and services and supplies provided in home Plan pays for only one visit per day up to 90 visits per year (4 hours = 1 visit) ***Out-of-Network:*** 50%*	***In-Network:*** Plan pays 100% of reasonable & customary charges for visits to home and services and supplies provided in home Plan pays for only one visit per day up to 90 visits per year (4 hours = 1 visit) ***Out-of-Network:*** 50%*	***In-Network:*** Plan pays 100% of reasonable & customary charges for visits to home and services and supplies provided in home Plan pays for only one visit per day up to 90 visits per year (4 hours = 1 visit) ***Out-of-Network:*** 60%*	***In-Network:*** Plan pays 100% of reasonable & customary charges for visits to home and services and supplies provided in home Plan pays for only one visit per day up to 90 visits per year (4 hours = 1 visit) ***Out-of-Network:*** 60%*	Covered in full	Covered in full
Hospice Care	***In-Network:*** 100% ***Out-of-Network:*** 50%* (some limits apply)	***In-Network:*** 100% ***Out-of-Network:*** 50%* (some limits apply)	***In-Network:*** 100% ***Out-of-Network:*** 60%* (some limits apply)	***In-Network:*** 100% ***Out-of-Network:*** 60%* (some limits apply)	Covered in full up to 180 days per lifetime	Covered in full up to 180 days per lifetime

* Paid after the deductible **Non-approved care is not covered. Care must be approved by PCP or PMG (Participating Medical Group). ***PCP is your Primary Care Physician

Comparison of Medical Plan Benefits For Retirees Age 65 or Over and Those Eligible for Medicare (Including Those Disabled)

This table summarizes benefits for each of the City's medical plans available to retirees age 65 or older. Plan year deductibles and/or copayments are the amount you pay each year (where applicable) before your plan begins paying benefits.

	Medicare Supplement Plan	PacifiCare Secure Horizons (Medicare Risk Plan)
Plan Year Deductible	***In-Network:*** $50 ***Out-of-Network:*** $50	No deductible
Lifetime Maximum	***In-Network:*** Unlimited ***Out-of-Network:*** Unlimited	Unlimited
Hospitalization	***In-Network:*** Days 1-60: Medicare deductible paid at 100% Days 61-90: All Covered Expenses not payable by Medicare will be paid at 100% Days 91-100: All Covered Expenses not payable by Medicare will be paid at 100% Days 101+: No Coverage Days ***Out-of-Network:*** Days 1-60: Medicare deductible paid at 100% Days 61-90: Medicare deductible paid at 100% Days 91-100: Plan pays the usual charges for semi-private room services for the hospital concerned Days 101+: No Coverage	Semi-private room covered in full for unlimited days
Hospital Preadmission Tests	***In-Network:*** Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare ***Out-of-Network:*** Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit	Covered in full
Inpatient & Outpatient Surgery	***In-Network:*** Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare ***Out-of-Network:*** Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit	Covered in full
Physician Charges for Hospital Care & Surgery	***In-Network:*** Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare ***Out-of-Network:*** Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit	Covered in full
Emergency Room	***In-Network:*** Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare ***Out-of-Network:*** Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit	$50 copay per visit. Waived if admitted to the hospital $25 copay for non-network out-of-area urgent care

Comparison of Medical Plan Benefits For Retirees Age 65 or Over and Those Eligible for Medicare (Including Those Disabled) (cont.)

	Medicare Supplement Plan	PacifiCare Secure Horizons (Medicare Risk Plan)
Physician Office Visits	***In-Network:*** Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare ***Out-of-Network:*** Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit	$5 copay per visit
Outpatient X-ray & Laboratory	***In-Network:*** Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare ***Out-of-Network:*** Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit	Covered in full
Maternity Care	***In-Network:*** Plan pays the Medicare deductible and 100% of allowable expenses not payable by Medicare ***Out-of-Network:*** Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit	Covered in full. Complete maternity care includes all care before, during and after birth (up to 6 weeks post-partum) Includes all medically indicated diagnostic testing and reasonable and necessary services associated with pregnancy
Routine Physical	Not covered	$5 copay per visit Limited to one exam each calendar year
Well-Baby Care	Not covered	Not covered
Prescription Drugs	***In-Network:*** When you use an Express Scripts pharmacy: $10 generic; $25 brand preferred; $40 or 30% for brand non-preferred. Mail Order available at 2 times applicable copay for 90-day supply. Subject to $2,000 paid maximum benefit per calendar year. ***Out-of-Network:*** When you use non-Express Scripts pharmacy, you must file a claim form with Express Scripts; the benefit amount paid will be reduced. Subject to $2,000 paid maximum benefit per calendar year.	$7 generic; $14 brand; 30-day supply. Mail order services available at 2 times the regular copay for 90-day supply; formulary applies.
Chiropractic Care	***In-Network:*** Plan pays 100% of all covered expenses not payable by Medicare ***Out-of-Network:*** Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit	You can self refer for a $5 copay per visit up to 12 visits per year
Acupuncture	***In-Network:*** Not covered ***Out-of-Network:*** Not covered	Not covered
Durable Medical Equipment (DME)	***In-Network:*** Plan pays 100% of all covered expenses not payable by Medicare if rented or purchased from a contracted facility ***Out-of-Network:*** Plan pays the Medicare deductible plus the remaining 20% of covered expenses up to the Medicare Allowable Expense Limit	Covered in full
Hearing Aids	Covered at 80% after the calendar year deductible. Benefit paid maximum of $1,000 every 3 years	$500 allowance every 2 years; hearing exam covered in full after $5 copay
Orthotics	Covered at 80% after the calendar year deductible. Maximum paid benefit of $75 every 3 years.	Therapeutic shoes and supportive devices for feet are covered only for those with diabetic foot disease.

Comparison of Medical Plan Benefits For Retirees Age 65 or Over and Those Eligible for Medicare (Including Those Disabled) (cont.)

	Medicare Supplement Plan	PacifiCare Secure Horizons (Medicare Risk Plan)
Vision Benefits	***In-Network:*** Not covered ***Out-of-Network:*** Not covered	$5 copay for exam; $125 materials allowance; glasses every 24 months
Inpatient Mental Health Treatment	***In-Network:*** Plan pays 100% of all Medicare eligible expenses not payable by Medicare for a confinement at a Medicare-participating hospital ***Out-of-Network:*** Plan pays the Medicare deductible and any applicable coinsurance for a confinement at a Medicare-participating hospital	Limited to a lifetime limit of 190 days in a Medicare-participating psychiatric hospital (combined with Inpatient Substance Abuse)
Outpatient Mental Health Benefits	***In-Network:*** Plan pays 100% of the eligible charges for the service, subject to a $250 calendar year maximum ***Out-of-Network:*** Plan pays 50% of Medicare Allowable Expenses (Medicare pays the other 50%) subject to a $250 calendar year maximum	$5 copay per visit; unlimited visits
Inpatient Substance Abuse Treatment	***In-Network:*** Not covered ***Out-of-Network:*** Not covered	Covered in full. Limited to 190 days lifetime maximum; combined with Inpatient Mental Health
Outpatient Substance Abuse Treatment	***In-Network:*** Not covered ***Out-of-Network:*** Not covered	$5 copay per visit
Skilled Nursing Facilities (SNF)	***In-Network:*** Plan pays 100% of all covered expenses not payable by Medicare up to the plan limit of 100 days ***Out-of-Network:*** Plan pays the daily coinsurance not payable by Medicare up to the Medicare Allowable Expense Limit. No plan benefit is payable after the 100th day	Covered in full for 100 days per benefit period
Home Health Care	Expenses for private duty nursing by an RN will be paid at 80% up to a lifetime maximum of $5,000 after a $50 calendar year deductible	Covered in full with no limit on number of visits when approved by PCP
Hospice Care	***In-Network:*** Plan pays 100% of all covered expenses not payable by Medicare ***Out-of-Network:*** Plan pays the Medicare copayments up to the Medicare Allowable Expense Limit	Covered in full if elected by member and determined medically necessary by PMG
Dental Care	***In-Network:*** Not covered ***Out-of-Network:*** Not covered	You pay $5 for each office visit up to 4 visits per year. You pay $0 for additional visits per year. You pay $15 for teeth cleaning; $10 for prescribed routine x-rays. You must use network providers. Some limits apply. See benefit book for details.

Notice to Participants

New Federal laws impose certain requirements on group health plans. Under these new Federal laws, collectively referred to as HIPAA, a group health plan is limited in imposing pre-existing conditions; must offer employees and dependents the opportunity to enroll in the plan outside of open enrollment periods in certain situations; cannot discriminate on the basis of health status with respect to eligibility for plan participation and premium costs; cannot impose discriminatory lifetime or annual benefit limitations for participants with mental illness; and must permit hospital admissions (if otherwise covered by the plan) of at least 24 hours in the case of normal deliveries and 48 hours in the case of Cesarean Sections.

With respect to many of the above restrictions, the City of Long Beach is currently in compliance with State law requirements and many of the HIPAA requirements under Federal law. Further, the City of Long Beach does not discriminate on the basis of health status with respect to eligibility for health plan participation or premium costs.

As part of the new Federal law, plan sponsors of non-Federal government plans can elect to be exempt from the above-mentioned requirements. The City of Long Beach has elected exemption from HIPAA requirements for the plan year beginning December 1, 2004 and ending the following November 30, 2005.

Special Assistance

This Retiree Benefits Summary information is available in an alternate format by request to the Department of Human Resources and Affirmative Action. If you need any special assistance or special materials to clearly and fully understand all of your benefit options, please call (562)570-6621. We would be more than happy to assist you in any way we can.

Special Notice

This Benefits Summary reviews health and dental benefits for the City of Long Beach, but it is not a contract. Full details about the benefits are provided in legal plan documents and insurance contracts that govern the program. If there are differences between this Benefits Summary and those documents and contracts, the legal documents will control.

The actual plan documents may be inspected upon written request to the Employee Benefits & Services Officer at least 10 days prior to review. A copy of the entire plan document(s) may be obtained in the same manner for a 25-cent per page copying charge.